

STEP THERAPY CRITERIA

This list is current as of November 1, 2024, and pertains to the following formularies:

2024 Pharmacy Benefit Dimensions PDP Part D Formulary Provided by City of Stamford	Version 20
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In some cases, we require that you first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. This document contains the Step Therapy protocols that are associated with the formularies listed above.

If you have any questions, please contact our Medicare Member Services Department at 1-800-667-5936 or, for TTY users 711, October 1st – March 31st: Monday through Sunday from 8 a.m. to 8 p.m. ET, April 1st – September 30th: Monday through Friday from 8 a.m. to 8 p.m. ET.

Pharmacy Benefit Dimensions is a subsidiary of Independent Health. Independent Health is a PDP with a Medicare contract. Enrollment in Pharmacy Benefit Dimensions PDP depends on contract renewal between Independent Health and CMS.

The formulary may change at any time. You will receive notice when necessary.

Aliskiren Step

Products Affected

- *aliskiren fumarate tablet 150 mg oral*
- *aliskiren fumarate tablet 300 mg oral*

Details

Criteria	Prior prescription history of an ARB to obtain any products containing aliskiren.
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Eucrisa Step

Products Affected

- EUCRISA OINTMENT 2 % EXTERNAL

Details

Criteria	Prior prescription history positive for the use of either a topical corticosteroid or topical calcineurin inhibitor.
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Hectoral Step Therapy

Products Affected

- *doxercalciferol capsule 0.5 mcg oral*
- *doxercalciferol capsule 1 mcg oral*
- *doxercalciferol capsule 2.5 mcg oral*

Details

Criteria	Prior Prescription history includes past use of calcitriol.
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Incretin Mimetic Step

Products Affected

- *liraglutide solution pen-injector 18 mg/3ml subcutaneous*
- MOUNJARO SOLUTION PEN-INJECTOR 10 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 12.5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 15 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 2.5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 7.5 MG/0.5ML SUBCUTANEOUS
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/3ML SUBCUTANEOUS
- OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4 MG/3ML SUBCUTANEOUS
- OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8 MG/3ML SUBCUTANEOUS
- RYBELSUS TABLET 14 MG ORAL
- RYBELSUS TABLET 3 MG ORAL
- RYBELSUS TABLET 7 MG ORAL
- TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5ML SUBCUTANEOUS
- VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS

Details

Criteria	Requires the use of another medication that is FDA-approved for the treatment of type 2 diabetes first. If the incretin mimetic is being used for risk reduction of major cardiovascular events in adults with type 2 diabetes and established cardiovascular disease, this criterion does not apply.
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Pregabalin ER Step

Products Affected

- *pregabalin er tablet extended release 24 hour 165 mg oral*
- *pregabalin er tablet extended release 24 hour 330 mg oral*
- *pregabalin er tablet extended release 24 hour 82.5 mg oral*

Details

Criteria	Requires the use of an immediate-release pregabalin product first.
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Qelbree Step

Products Affected

- QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL
- QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL
- QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL

Details

Criteria	Requires the use of generic atomoxetine first.
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Talicia Step

Products Affected

- TALICIA CAPSULE DELAYED RELEASE 250-12.5-10 MG
ORAL

Details

Criteria	Prior prescription history positive for the use of an empiric (standard first-line) Helicobacter pylori regimen.
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Topical Rosacea Step

Products Affected

- EPSOLAY CREAM 5 % EXTERNAL
- FINACEA FOAM 15 % EXTERNAL

Details

Criteria	Prior prescription history of at least one other topical rosacea medication used for papules/pustules including azelaic acid gel, ivermectin cream, or metronidazole products.
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Tramadol ER

Products Affected

- *tramadol hcl (er biphasic) tablet extended release 24 hour 100 mg oral*
- *tramadol hcl (er biphasic) tablet extended release 24 hour 200 mg oral*
- *tramadol hcl (er biphasic) tablet extended release 24 hour 300 mg oral*
- *tramadol hcl er tablet extended release 24 hour 100 mg oral*
- *tramadol hcl er tablet extended release 24 hour 200 mg oral*
- *tramadol hcl er tablet extended release 24 hour 300 mg oral*

Details

Criteria	Requires the use of tramadol immediate release first
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Uloric Step

Products Affected

- *febuxostat tablet 40 mg oral*
- *febuxostat tablet 80 mg oral*

Details

Criteria	Requires allopurinol prior to use.
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Xphozah Step

Products Affected

- XPHOZAH TABLET 20 MG ORAL
- XPHOZAH TABLET 30 MG ORAL

Details

Criteria	Requires the maintenance use of a traditional phosphate binder such as calcium acetate, ferric citrate, lanthanum carbonate, sevelamer, or sucroferric oxyhydroxide. This step therapy is required at each fill.
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ZEMPLAR STEP THERAPY

Products Affected

- RAYALDEE CAPSULE EXTENDED RELEASE 30 MCG
ORAL

Details

Criteria	Prior Prescription history includes past use of calcitriol.
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Index

<i>aliskiren fumarate tablet 150 mg oral</i>	2	<i>tramadol hcl (er biphasic) tablet extended release</i>	
<i>aliskiren fumarate tablet 300 mg oral</i>	2	<i>24 hour 200 mg oral</i>	10
<i>doxercalciferol capsule 0.5 mcg oral</i>	4	<i>tramadol hcl (er biphasic) tablet extended release</i>	
<i>doxercalciferol capsule 1 mcg oral</i>	4	<i>24 hour 300 mg oral</i>	10
<i>doxercalciferol capsule 2.5 mcg oral</i>	4	<i>tramadol hcl er tablet extended release 24 hour 100</i>	
EPSOLAY CREAM 5 % EXTERNAL	9	<i>mg oral</i>	10
EUCRISA OINTMENT 2 % EXTERNAL	3	<i>tramadol hcl er tablet extended release 24 hour 200</i>	
<i>febuxostat tablet 40 mg oral</i>	11	<i>mg oral</i>	10
<i>febuxostat tablet 80 mg oral</i>	11	<i>tramadol hcl er tablet extended release 24 hour 300</i>	
FINACEA FOAM 15 % EXTERNAL	9	<i>mg oral</i>	10
<i>liraglutide solution pen-injector 18 mg/3ml</i>		TRULICITY SOLUTION PEN-INJECTOR 0.75	
<i>subcutaneous</i>	5	MG/0.5ML SUBCUTANEQUS	5
MOUNJARO SOLUTION PEN-INJECTOR 10		TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5ML	
MG/0.5ML SUBCUTANEQUS	5	SUBCUTANEQUS	5
MOUNJARO SOLUTION PEN-INJECTOR 12.5		TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5ML	
MG/0.5ML SUBCUTANEQUS	5	SUBCUTANEQUS	5
MOUNJARO SOLUTION PEN-INJECTOR 15		TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5ML	
MG/0.5ML SUBCUTANEQUS	5	SUBCUTANEQUS	5
MOUNJARO SOLUTION PEN-INJECTOR 2.5		VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML	
MG/0.5ML SUBCUTANEQUS	5	SUBCUTANEQUS	5
MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5ML		XPHOZAH TABLET 20 MG ORAL	12
SUBCUTANEQUS	5	XPHOZAH TABLET 30 MG ORAL	12
MOUNJARO SOLUTION PEN-INJECTOR 7.5			
MG/0.5ML SUBCUTANEQUS	5		
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-			
INJECTOR 2 MG/3ML SUBCUTANEQUS	5		
OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4			
MG/3ML SUBCUTANEQUS	5		
OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8			
MG/3ML SUBCUTANEQUS	5		
<i>pregabalin er tablet extended release 24 hour 165</i>			
<i>mg oral</i>	6		
<i>pregabalin er tablet extended release 24 hour 330</i>			
<i>mg oral</i>	6		
<i>pregabalin er tablet extended release 24 hour 82.5</i>			
<i>mg oral</i>	6		
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR			
100 MG ORAL	7		
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR			
150 MG ORAL	7		
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR			
200 MG ORAL	7		
RAYALDEE CAPSULE EXTENDED RELEASE 30 MCG			
ORAL	13		
RYBELSUS TABLET 14 MG ORAL	5		
RYBELSUS TABLET 3 MG ORAL	5		
RYBELSUS TABLET 7 MG ORAL	5		
TALICIA CAPSULE DELAYED RELEASE 250-12.5-10			
MG ORAL	8		
<i>tramadol hcl (er biphasic) tablet extended release</i>			
<i>24 hour 100 mg oral</i>	10		